RESTORE HEALTH

THRIVE FROM THE INSIDE OUT

Distance Testing

New Client Information Packet

At Restore Health, your health journey is our highest priority — even from a distance. We've reserved an appointment slot just for you, and we want to gather as much information as possible so we can build the most effective protocol for your unique needs.

To help us prepare, please read through this packet carefully. Complete all required forms and return them — along with your samples — no less than 2 weeks before your appointment. Don't worry: this paperwork only needs to be completed once, for your first appointment.

Required Forms Checklist

Required Form	Reference
☐ Health Questionnaire	*Pages 3–5*
☐ Signed Informed Consent	*Page 6*
☐ Signed Office Policies	*Pages 7–8*
☐ Commitment Statement	*Page 9*
☐ Standard Process Stress Assess	*Page 10*
☐ Symptom Survey	*Pages 11-12*
☐ Digestive Screening Questionnaire	*Page 13*
☐ Picture of Yourself	*Mailed or Text*
☐ Tracking Form	*Page 14*
☐ Any Recent Lab Work	*Within 1 year*

Sample Collection Instructions

For your first appointment and every one that follows, we need the following samples:

1	**Cotton Swabs**	Take 2 Q-Tips and rub and roll around on the inside of each cheek, using both ends. Do this before toothpaste, coffee, gum, candy, or any meal.
2	**Nail Clippings**	Collect a few nail clippings (finger or toe). Nails should be clean, no polish.
3	**Hair Strands**	Cut strands of hair — if you get the root it is a bonus. Hair free of spray, gel, or products. Aim for approximately ⅛ teaspoon of hair.
4	**Package Samples**	Place all items together in one thin baggie. Do not label the bag with a marker.
5	**Mail Everything**	Send samples and completed forms to: Restore Health • 688 McHenry Street, Burlington, WI 53105

Client Health Questionnaire Date: _____

Name: _____ Date of Birth _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email _____

Did anyone refer you? _____

Chief Complaint – What is the main reason you are seeking care?

_____

_____

_____

Duration of Present Condition?

_____

What do you believe caused this Condition?

_____

When were you last seen by a Physician?

_____

For what purpose?

_____

Diagnosis by your Doctor?

_____

Any abnormal lab results or tests?

_____

Prior surgeries?

_____

Medications you are presently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Supplements or Over the Counter drugs you are taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Lifestyle & Dietary Habits

Substance	Yes	No	How much and how often?
Coffee	☐	☐	
Tea	☐	☐	
Alcohol	☐	☐	
Chocolate	☐	☐	
Cigarettes	☐	☐	
Laxatives	☐	☐	
Sugar	☐	☐	
Artificial Sweeteners	☐	☐	

List any foods that you crave: _____

List any known allergies: _____

Do you have a Pacemaker (Yes / No): _____ **Are you pregnant (Yes / No):** _____

Meridian Health Assessment

Please indicate how often you experience each of the following conditions:

Meridian	Question	Never	Sometimes	Often
Lymphatic	Do you experience recurrent infections, sinusitis, postnasal drip, or swollen lymph nodes?	☐	☐	☐
Lungs	Do you experience recurrent respiratory infections, coughs, bronchitis, pneumonia, asthma?	☐	☐	☐
Large Intestines	Do you experience bouts of diarrhea or constipation, gas, bloating?	☐	☐	☐
Nervous	Do you experience irritability, nervousness, trembling, anxiety, or memory problems?	☐	☐	☐
Circulation	Do you have cold fingers or toes, blood pressure problems, varicose veins, arteriosclerosis?	☐	☐	☐
Allergies	Do you react to pollens, molds, foods, seasonal irritants, perfumes, animal dander?	☐	☐	☐
Cellular Metabolism	Do you have slow metabolism, are you always hungry, have low energy at specific times?	☐	☐	☐
Endocrine System	Do you have mood swings, problems sleeping, are you always cold, have chemical imbalances?	☐	☐	☐
Heart	Do you experience palpitations, arrhythmia, impairments from prior infections, weak valves?	☐	☐	☐
Conception Vessel	Do you have impotence, miscarriage, sterility, gynecological or genital disorders?	☐	☐	☐

Meridian	Question	Never	Sometimes	Often
Small Intestine	Do you have recurrent yeast infections, frequent antibiotic use, poor diet, gas, bloating?	☐	☐	☐
Governing Vessel	Do you experience spinal stiffness or pain, headaches, mental confusion, depression?	☐	☐	☐
Pancreas	Do you have diabetes, hypoglycemia, irritability, shaking if you skip a meal?	☐	☐	☐
Spleen	Do you experience chronic fatigue, recurring infections, lowered immune response?	☐	☐	☐
Liver	Do you experience jaundice, high cholesterol, discomfort in the liver region, blood disorder?	☐	☐	☐
Joints	Do you have arthritis, back pain, discomfort when moving, weather-triggered ailments?	☐	☐	☐
Stomach	Do you have digestive disturbances, high acidity, bloating or gas after meals?	☐	☐	☐
Muscle, Ligaments, Tendons	Do you have fibromyalgia, rheumatism, carpal tunnel, slow recovery after exercise?	☐	☐	☐
Skin	Do you have rashes, dryness or cracking, scaly patches, eczema, acne, psoriasis?	☐	☐	☐
Fatty Tissue	Do you have lipomas, degenerative liver disease, breast tumors, problems burning fat?	☐	☐	☐
Gall Bladder	Do you have a history of gallstones, discomfort after eating rich foods, low fat metabolism?	☐	☐	☐
Kidney	Do you experience edema, gout, pain in the lower back, burning urination, kidney stones?	☐	☐	☐
Urinary	Do you have recurring infections, itching or yeast problems, painful urination, “leaking”?	☐	☐	☐
Female	Do you have PMS, menstrual pains, irregular periods, mood swings, menopausal symptoms?	☐	☐	☐
Male	Do you experience urinary discomfort or frequency of urination?	☐	☐	☐
Teeth	Do you have sensitive teeth or experience pain or discomfort in the teeth, gums, or jaw?	☐	☐	☐
Stress	Do you experience stress from work, finances, society, or relationships causing physical ailments?	☐	☐	☐
Energy	Do you lack motivation, drive, perseverance, stamina, or endurance?	☐	☐	☐
Well-Being	Do you lack a sense of happiness, joy, feelings of fulfillment, a positive outlook on life?	☐	☐	☐
Immune	Are you susceptible to infections, allergies, or sensitive to pollution or work environment?	☐	☐	☐

Informed Consent

Galvanic Skin Response Testing (GSR) & Meridian Stress Assessment (MSA)

Procedure

The testing system used in this office measures electrical conductivity at 58 key points on the hands and feet. These points create "circuits" in your body related to specific organs and systems. A metal probe is touched to the skin surface at each point to collect the data. The process is quick, non-invasive, and comprehensive. This system is an FDA-registered Class II device.

Counseling

Once testing is complete, data is compiled, reports are produced, and recommendations are made. Your practitioner will consider dietary and lifestyle changes, herbal medicine, whole food nutritional products, flower essences, homeopathic remedies, and other natural means to bring abnormal electrical patterns into equilibrium. We do not diagnose or treat disease; however, if testing indicates unusual findings, we will advise you to pursue medical counsel.

Questions

Your practitioner will answer any questions you may have about the test and reports.

Payment

You are responsible for payment of fees associated with testing, along with any recommended products or remedies. We accept cash, check, and all major credit cards. Check with your HSA and FSA for coverage.

Initial MSA Scan & Recommendation: $295.00 • *Repeat MSA Scan & Recommendation: $145.00*

Important Notes

All recommended substances are safe when taken as directed. Report any adverse reactions to your practitioner immediately. Please discuss significant health concerns (Diabetes, high blood pressure, heart conditions, etc.) at your first visit and update us regularly.

The testing device uses a low-voltage current. If you have a pacemaker or similar electronic implant, testing cannot proceed without signed consent from your primary care physician.

I have read and understand the above information regarding the Galvanic Skin Response procedure and hereby provide consent for testing with this equipment. I also consent for clinical reports and results of my case to be used for advancing clinical knowledge, research, and scientific purposes, provided my identity remains confidential.

Patient Name (print): **Date:**

Signature:

☐ *Check if signing on behalf of a minor*

Office Policies

Office Hours

Our office operates Monday through Friday, 9:00 AM – 5:00 PM. Email and phone correspondence received during those hours will be addressed within 24 business hours and as quickly as possible.

Scheduling Appointments

We recommend scheduling follow-up appointments at checkout — schedules fill quickly. If that's not possible, appointments may be booked by calling our office directly.

New vs. Returning Client

The human body is ever-changing; accidents, prescriptions, emotion changes, human physiology, our liver rejuvenates in 7 years. In order to provide the best care for you, if you have not been assessed at Restore Health in over 18 months, you will be considered a new client and will need a new client appointment.

Supplement Orders

Orders must be paid and placed by 12:00 PM on business days. Orders received after this time will be prepared the following business day. We ship Monday–Friday with a $25 minimum order. We share shipping costs — you are only charged $5 (subject to change based on USPS fees).

Cancellation Policy

We ask for 48-hour notice (2 business days) if you need to cancel or reschedule or will incur a $40 fee. A second occurrence results in a fee equal to the full assessment amount. New appointment cancellations without 48-hour notice forfeit your $50 deposit. After multiple cancellations, full prepayment may be required to hold your appointment.

Lab Testing

Additional lab testing may be ordered as appropriate. All tests must be completed by the client for whom they were ordered and must not be given to another individual. There are no returns or refunds for outside lab testing.

Email Questions

We welcome questions between appointments! To ensure thorough responses, please combine all questions into a single email sent to info@restore-health.net. If your questions require significant time to address, an additional charge of $2/min may apply.

Purchasing Supplements

We strongly recommend ordering all supplements through our office. Online resellers, including Amazon, have acknowledged issues with counterfeit products that appear identical to genuine items but lack the listed nutrients or herbs. If you purchase recommended supplements elsewhere, a flat $100 fee will be added to your next assessment.

Supplement Returns

There is a 15-day return period for unopened and undamaged products. Items being returned must have an expiration date within 3 months of the return request.

Right to Refuse Care

Maintaining mutual trust and respect is essential to our practitioner-client relationship. If at any time the Restore Health team believes the relationship is not beneficial or lacks forward progress, we reserve the right to terminate the relationship and provide a referral to another qualified practitioner.

I have read and understand the above policies:

Signature: **Date:**

Commitment Statement

Research from Johns Hopkins, Harvard, Sacramento, and other leading institutions confirms that a person's attitude plays a significant role in their health and quality of life.

The supplements recommended to you will play a role in your healing — but more importantly, your attitude and commitment will be vital.

♥ *Will you take the necessary steps to conquer your health?*

I commit to:

- ✓ Wanting to have optimal health
- ✓ Maintaining a positive attitude and an open mind
- ✓ Following through with the agreed-upon protocol
- ✓ Believing that my symptoms are in the past and that I will be well

What steps will you take to improve your health?

_____

_____

_____

I want to be your teammate. My promise to you is: I will give 100% to your health. If I don't know an answer, I will find it. I will continue to learn and study the functions of the body and what it takes to restore your health.

You are the biggest variable in your health — You got this!

STANDARD PROCESS STRESS ASSESS™

Please answer the following questions based on your experience within the last month.

	Not at All 1	A Little 2	Somewhat 3	Quite a Bit 4	Very Much 5
1. How stressful would you say your life is?	○	○	○	○	○
2. Dealing with daily stresses is negatively affecting my daily tasks.	○	○	○	○	○
3. I have a high intake of sugar and/or processed foods.	○	○	○	○	○
4. I feel worn down and/or burnt out.	○	○	○	○	○
5. I need caffeine or other energy drinks in the morning or afternoon to give me energy.	○	○	○	○	○
6. I seem to have lower than usual energy during the day.	○	○	○	○	○
7. I experience body aches and pains.	○	○	○	○	○
8. I have periods of low moods.	○	○	○	○	○
9. I feel more irritable.	○	○	○	○	○
10. My weight and metabolism have changed.	○	○	○	○	○
11. I can't seem to focus or concentrate.	○	○	○	○	○
12. I have feelings of anxiousness.	○	○	○	○	○
13. I feel totally exhausted most of the day and only have a few productive hours.	○	○	○	○	○
14. I find myself pushing through fatigue to get things done.	○	○	○	○	○
15. I seem to be sleeping a lot but never feel quite rested. I wake up feeling tired.	○	○	○	○	○
16. I have difficulty getting to sleep and/or wake up in the middle of the night.	○	○	○	○	○
17. I experience strong cravings for sweet or salty foods.	○	○	○	○	○
18. I feel overwhelmed with daily tasks and all that is on my plate.	○	○	○	○	○
19. I have a low sex drive.	○	○	○	○	○
20. I am unable to enjoy socializing with family and/or friends.	○	○	○	○	○

Add up your total score and mark where you fall on the stress scale below. Total: _____

20 – 40 • Low Stress	40 – 70 • Moderate Stress	70 – 100 • High Stress
Stress is fairly well managed. Support your body to continue its healthy response.	*Your body's stress response may be affecting normal activities. Consult your health care professional.*	*You may have experienced prolonged stress. Consult your health care professional for targeted support.*

Have you experienced any significant life events or changes in the last three months (illness, injury, job change, new baby, marriage, divorce, extreme training, major project, etc.)? If so, please list:

Do you have any downtime or participate in quiet mindfulness activities? (Pilates, yoga, prayer, quiet walks, personal hobbies) **Yes** ○ **No** ○

Hours of sleep / Night	○ 3–4	○ 5–6	○ 7–8	○ 9+
Hours exercised / Week	○ 0	○ 1–2	○ 3–5	○ 6+
Alcoholic drinks / Week	○ 0	○ 1–2	○ 3–7	○ 8+
Meals eaten out / Week	○ 0	○ 1–2	○ 3–5	○ 6+

Name: Date:

Systems Survey Form

INSTRUCTIONS: Circle the number that applies to you. *If a symptom does not apply*, don't circle anything.

1 MILD (rarely) **2** MODERATE (several times/month) **3** SEVERE (almost constantly)

GROUP 1

1. **1 2 3** Acid foods upset
2. **1 2 3** Get chilled often
3. **1 2 3** "Lump" in throat
4. **1 2 3** Dry mouth, eyes, nose
5. **1 2 3** Pulse speeds after meal
6. **1 2 3** Keyed up, fail to calm
7. **1 2 3** Gag occasionally
8. **1 2 3** Unable to relax, startle easily
9. **1 2 3** Extremities cold, clammy
10. **1 2 3** Strong light irritates
11. **1 2 3** Occasionally weak urine flow
12. **1 2 3** Heart pounds after retiring
13. **1 2 3** "Nervous" stomach
14. **1 2 3** Appetite reduced occasionally
15. **1 2 3** Cold sweats often
16. **1 2 3** Get heated easily
17. **1 2 3** Nerve discomfort
18. **1 2 3** Staring, blink little
19. **1 2 3** Sour stomach frequent

TOTAL 1 ___ 2 ___ 3 ___

GROUP 2

20. **1 2 3** Joint stiffness after arising
21. **1 2 3** Muscle, leg, toe cramps at night
22. **1 2 3** "Butterfly" stomach, cramps
23. **1 2 3** Eyes or nose watery
24. **1 2 3** Eyes blink often
25. **1 2 3** Eyelids swollen, puffy
26. **1 2 3** Indigestion soon after meals
27. **1 2 3** Always seem hungry, feel "lightheaded" often
28. **1 2 3** Digestion rapid
29. **1 2 3** Vomit occasionally
30. **1 2 3** Hoarseness frequent
31. **1 2 3** Uneven breathing
32. **1 2 3** Pulse slow
33. **1 2 3** Gagging reflex slow
34. **1 2 3** Difficulty swallowing
35. **1 2 3** Temporary constipation or diarrhea
36. **1 2 3** "Slow starter"
37. **1 2 3** Get "chilled"
38. **1 2 3** Perspire easily
39. **1 2 3** Sensitive to cold
40. **1 2 3** Upper respiratory challenges

TOTAL 1 ___ 2 ___ 3 ___

GROUP 3

41. **1 2 3** Eat when nervous
42. **1 2 3** Excessive appetite
43. **1 2 3** Hungry between meals
44. **1 2 3** Irritable before meals
45. **1 2 3** Get "shaky" if hungry
46. **1 2 3** Fatigue, eating relieves
47. **1 2 3** "Lightheaded" if meals delayed
48. **1 2 3** Heart palpitates if meals missed or delayed
49. **1 2 3** Fatigue in afternoon
50. **1 2 3** Overeating sweets upsets
51. **1 2 3** Awaken after few hours sleep, hard to get back to sleep
52. **1 2 3** Crave candy or coffee in afternoon
53. **1 2 3** Moods of "blues" or melancholy
54. **1 2 3** Craving for sweets or snacks

TOTAL 1 ___ 2 ___ 3 ___

GROUP 4

55. **1 2 3** Hands and feet go to sleep easily, numbness
56. **1 2 3** Sigh frequently, "air hunger"
57. **1 2 3** Aware of "breathing heavily"
58. **1 2 3** High-altitude discomfort
59. **1 2 3** Open windows in closed room
60. **1 2 3** Immune system challenges
61. **1 2 3** Afternoon "yawner"
62. **1 2 3** Get "drowsy" often
63. **1 2 3** Swollen ankles worse at night
64. **1 2 3** Muscle cramps, worse during exercise; get "charley horse"
65. **1 2 3** Difficulty catching breath, especially during exercise
66. **1 2 3** Tightness or pressure in chest, worse on exertion
67. **1 2 3** Skin discolors easily after impact
68. **1 2 3** Tendency to anemia
69. **1 2 3** Noises in head or "ringing in ears"
70. **1 2 3** Fatigue upon exertion

TOTAL 1 ___ 2 ___ 3 ___

GROUP 5

71. **1 2 3** Dizziness
72. **1 2 3** Dry skin
73. **1 2 3** Burning feet
74. **1 2 3** Blurred vision
75. **1 2 3** Itching skin and feet
76. **1 2 3** Hair loss
77. **1 2 3** Occasional skin rashes
78. **1 2 3** Bitter, metallic taste in mouth in morning
79. **1 2 3** Occasional constipation
80. **1 2 3** Worrier, feels insecure
81. **1 2 3** Nausea occasionally after eating
82. **1 2 3** Greasy foods upset
83. **1 2 3** Stools light-colored
84. **1 2 3** Skin peels on foot soles
85. **1 2 3** Discomfort between shoulder blades
86. **1 2 3** Occasional laxative use
87. **1 2 3** Stools alternate from soft to watery
88. **1 2 3** Sneezing attacks
89. **1 2 3** Dreaming, nightmare-type bad dreams
90. **1 2 3** Bad breath (halitosis)
91. **1 2 3** Milk products cause upset
92. **1 2 3** Sensitive to hot weather
93. **1 2 3** Burning or itching anus
94. **1 2 3** Crave sweets

TOTAL 1 ___ 2 ___ 3 ___

GROUP 6

95. **1 2 3** Loss of taste for meat
96. **1 2 3** Lower bowel gas several hours after eating
97. **1 2 3** Burning stomach sensations, eating relieves
98. **1 2 3** Coated tongue
99. **1 2 3** Pass large amounts of foul-smelling gas
100. **1 2 3** Indigestion 1/2-1 hour after eating; up to 3-4 hours after
101. **1 2 3** Watery or loose stool
102. **1 2 3** Gas shortly after eating
103. **1 2 3** Stomach "bloating"

TOTAL 1 ___ 2 ___ 3 ___

GROUP 7B

119. **1 2 3** Increase in weight
120. **1 2 3** Decrease in appetite
121. **1 2 3** Fatigue easily
122. **1 2 3** Ringing in ears
123. **1 2 3** Sleepy during day
124. **1 2 3** Sensitive to cold
125. **1 2 3** Dry or scaly skin
126. **1 2 3** Temporary constipation
127. **1 2 3** Mental sluggishness
128. **1 2 3** Hair coarse, falls out
129. **1 2 3** Tension in head upon arising wears off during day
130. **1 2 3** Slow pulse below 65
131. **1 2 3** Changing urinary function
132. **1 2 3** Sounds appear diminished
133. **1 2 3** Reduced initiative

TOTAL 1 ___ 2 ___ 3 ___

GROUP 7C

134. **1 2 3** Failing memory with age
135. **1 2 3** Increased sex drive
136. **1 2 3** Episodes of tension in head
137. **1 2 3** Decreased sugar tolerance

TOTAL 1 ___ 2 ___ 3 ___

GROUP 7D

138. **1 2 3** Abnormal thirst
139. **1 2 3** Bloating of abdomen
140. **1 2 3** Weight gain around hips or waist
141. **1 2 3** Sex drive reduced or lacking
142. **1 2 3** Tendency for stomach issues
143. **1 2 3** Immune system challenges
144. **1 2 3** Menstrual disorders

TOTAL 1 ___ 2 ___ 3 ___

GROUP 7E

145. **1 2 3** Dizziness
146. **1 2 3** Headaches
147. **1 2 3** Hot flashes
148. **1 2 3** Hair growth on face or body (female)
149. **1 2 3** Sugar in urine (not diabetes)
150. **1 2 3** Masculine tendencies (female)

TOTAL 1 ___ 2 ___ 3 ___

GROUP 7F

151. **1 2 3** Weakness, dizziness
152. **1 2 3** Tired throughout day
153. **1 2 3** Nails weak, ridged
154. **1 2 3** Sensitive skin
155. **1 2 3** Stiff joints
156. **1 2 3** Perspiration increase
157. **1 2 3** Bowel discomfort
158. **1 2 3** Poor circulation
159. **1 2 3** Swollen ankles
160. **1 2 3** Crave salt
161. **1 2 3** Areas of skin darkening
162. **1 2 3** Upper respiratory sensitivity
163. **1 2 3** Tiredness
164. **1 2 3** Breathing challenges

TOTAL 1 ___ 2 ___ 3 ___

GROUP 8

165. **1 2 3** Muscle weakness
166. **1 2 3** Lack of stamina
167. **1 2 3** Drowsiness after eating
168. **1 2 3** Muscular soreness
169. **1 2 3** Heart races
170. **1 2 3** Hyperirritable
171. **1 2 3** Feeling of a band around head
172. **1 2 3** Melancholia (feeling of sadness)
173. **1 2 3** Swelling of ankles
174. **1 2 3** Change in urinary function
175. **1 2 3** Tendency to consume sweets/carbohydrates
176. **1 2 3** Muscle spasms
177. **1 2 3** Blurred vision
178. **1 2 3** Involuntary muscle action
179. **1 2 3** Numbness
180. **1 2 3** Night sweats
181. **1 2 3** Rapid digestion
182. **1 2 3** Sensitivity to noise
183. **1 2 3** Redness of palms of hands and bottom of feet
184. **1 2 3** Visible veins on chest and abdomen
185. **1 2 3** Hemorrhoids
186. **1 2 3** Apprehension (feeling that bad is going to happen)
187. **1 2 3** Nervousness causing loss of appetite
188. **1 2 3** Nervousness with indigestion
189. **1 2 3** Gastritis
190. **1 2 3** Forgetfulness
191. **1 2 3** Thinning hair

TOTAL 1 ___ 2 ___ 3 ___

FEMALE ONLY

192. **1 2 3** Very easily fatigued
193. **1 2 3** Premenstrual tension
194. **1 2 3** Menses more painful than usual
195. **1 2 3** Depressed feelings before menstruation
196. **1 2 3** Painful breasts during menses
197. **1 2 3** Menstruate too frequently
198. **1 2 3** Hysterectomy/ovaries removed
199. **1 2 3** Menopausal hot flashes
200. **1 2 3** Menses scanty or missed
201. **1 2 3** Acne, worse at menses

TOTAL 1 ___ 2 ___ 3 ___

MALE ONLY

202. **1 2 3** Less involved in exercise/social activities
203. **1 2 3** Difficult to postpone urination
204. **1 2 3** Weak urinary stream
205. **1 2 3** Feeling of "blues" or melancholy
206. **1 2 3** Feeling of incomplete bowel evacuation
207. **1 2 3** Lack of energy
208. **1 2 3** Muscles in arms and legs seem softer/smaller
209. **1 2 3** Tire too easily
210. **1 2 3** Avoid activity
211. **1 2 3** Leg nervousness at night
212. **1 2 3** Diminished sex drive

TOTAL 1 ___ 2 ___ 3 ___

IMPORTANT | main physical complaints (in order of importance):

1. _____
2. _____
3. _____
4. _____
5. _____

Name: Date:

GENERAL HEALTH & BACKGROUND

In the last 3 months:

	Yes	No
Glasses of water per day? (indicate #)		
Servings of fruit per day? (indicate #)		
Do you eat sushi?		
Do you consume dairy products?		
Antibiotics in last 3 months or extended period in last 10 years?		
Traveled out of country in last 10 years?		
Any food allergy / sensitivity testing performed?		

Diagnosed with:

	Yes	No
Ulcers (gastric / duodenal)		
GERD / Reflux		
Pancreatitis		
Celiac Disease		
IBD / IBS / Colitis		

Do you take:

	Yes	No
OTC Antacids		
OTC Laxatives / Fiber		
Other digestive aids (please list below)		
Prescription meds for digestion (please list below)		

Prescription meds / other aids:

STOMACH / UPPER DIGESTIVE SYMPTOMS

	Yes	No
Stomach burns / hurts even when empty (not hunger pangs)		
Eating or drinking relieves the above		
Eating or drinking makes it worse		
Stomach starts burning or bloated immediately after eating/drinking		
Stomach starts burning or bloated 30 min to several hours after eating/drinking		
Certain foods make this worse (list below)		
I have been diagnosed with 'Reflux' or 'GERD'		

Foods that make this worse / what relieves it:

If Reflux/GERD – worse: lying down OR all the time (circle one)

LOWER DIGESTIVE (Gas, Bloating, Constipation, Diarrhea)

	Yes	No
At least 1 normal bowel movement each day		
Stools: small and round or hard		
Stools: thin – pencil like		
Stools: pasty or fatty		
Stools: loose		
Stools: very foul		
Gas: not offensive		
Gas: very offensive and embarrassing		
Foods aggravate gas (list below)		
Often have to strain to have a bowel movement		
Often have cramping and pain with a bowel movement		
Abdominal cramping / pain even without a bowel movement		
Undigested food in stool (especially vegetable matter)		

Foods that aggravate gas:

Foods that make GERD / heartburn worse:

What relieves heartburn or GERD:

Tracking Form – record all your results on this page

Name: **Date:**

Baking Soda for Stomach Activity Chart

	Day 1	Day 2	Day 3	Day 4	Day 5
Time Until First Burp					
Time Test was Performed					

Candida Saliva Observation Chart

Time	Floating Clear Saliva	Strings (Like Legs)	Cloudy Specks in Water	Cloudy Saliva Sinking	Notes
Immediate					
1 minute					
5 minutes					
10 minutes					
15 minutes					

Metabolic pH Assessment Chart

Test	Result	Time Performed
Breath Hold Time (seconds)		
Respiration Rate (# of breaths)		

How To Instructions

The following pages are directions and insights to the at home tests we would like you to complete. Let us know if you have any questions. Do your best and we will glean from your results. Log all your results on the "tracking form" on page 14.

Baking Soda Test for Stomach Acidity

Overview

This is a simple test to approximate your stomach's acid level so it can be treated appropriately.

Your stomach produces hydrochloric acid, which digests your food. The baking soda solution reacts with this acid to produce carbon dioxide gas — the amount of gas depends on how much acid your stomach contains.

Directions

a. Perform this test first thing in the morning on an empty stomach, before eating or drinking anything.

b. Dissolve ¼ teaspoon of baking soda into an 8 oz. glass of cold water.

c. Drink the solution and immediately start timing.

d. Record how long it takes for you to first burp in the chart on the Tracking Form.

e. Perform this test for three or more consecutive days at the same time each day for the best estimation of your stomach's acidity.

Candida Spit Test

Overview

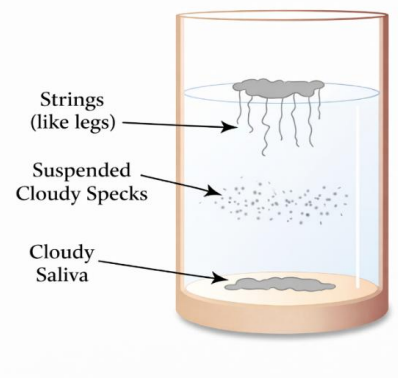
Candida is a type of yeast (a fungus) that naturally lives in the body — particularly in the mouth, digestive tract, skin, and vaginal area. In a healthy body, Candida exists in balance with beneficial bacteria and other microorganisms. However, factors such as antibiotic use, high sugar intake, chronic stress, weakened immunity, hormonal changes, or digestive imbalances may allow Candida to multiply beyond normal levels.

Directions

a. Fill a clear glass with water and place it by your bed the night before. When you wake, work up a bit of saliva and spit into the glass. Do not use throat clearings.

b. DO NOT drink any water, eat any food, brush your teeth, or kiss your partner before expressing saliva into the glass.

c. Using the Candida Saliva Observation Chart on the Tracking Form, immediately note how the saliva looks. Check it again at each marked time and observe any changes over a 15-minute period.



Metabolic pH Assessment Test

Overview

It is essential that your body maintain a well-balanced pH system. pH measures acidity and alkalinity — different parts of the body require different pH levels to function optimally.

Test #1: Breath Hold Test

a. This test measures how long you can hold a deep breath. You will need a stopwatch.

b. It is best to have a family member or friend do the timing so you can focus on holding your breath.

c. Find a comfortable chair. When ready, take a deep breath and hold it. The timer begins as soon as you start holding.

d. Hold your breath until it becomes uncomfortable or you feel you must inhale. This is not an endurance test!

e. Release and record the number of seconds in the chart on the Tracking Form.

Test #2: Respiration Rate Test

a. This test measures how many breaths you take in one minute. You will need a stopwatch or timer.

b. Have a family member or friend time you so your focus does not alter your breathing rate.

c. Lie down and wait a minute for your breathing to normalize before starting the timer. Try to relax and not think about your breathing.

d. The person timing you should begin the timer and count breaths from the first sign of an inhale — observable by watching your chest rise and fall, or by placing a hand on your stomach.

e. Count the number of breaths during the full 60 seconds and record the result on the Tracking Form.